



PREGNANCY NOTIFICATION REPORT

Please Fax to 877-708-2117
Attention: Prenatal RN Case Manager

MEMBER INFORMATION

Last Name	First Name	DOB:	ID#:
Address:	City:	Zip:	Phone#:
Date of Initial Prenatal Visit:		Completion date of Pregnancy Report:	

CURRENT PREGNANCY

Gravida:	Para:	LMP:	EDC:	Trimester:	Blood Type:
<input type="checkbox"/> Maternal age ≤ 16 years of age		<input type="checkbox"/> Maternal age ≥ 35 years of age		<input type="checkbox"/> Multiple Gestation this pregnancy	

PREVIOUS PREGNANCIES (check all that apply)

<input type="checkbox"/> Multiple Gestation previous pregnancy		<input type="checkbox"/> Hx of Post Partum Depression	
<input type="checkbox"/> Maternal age ≤ 16 years of age	<input type="checkbox"/> Hx of Placenta Previa	<input type="checkbox"/> Multiple Gestation this pregnancy	
<input type="checkbox"/> Hx of SAB/TAB/Fetal Demise		Week of Demise _____	Week of Delivery: _____

MEDICAL HISTORY (check all that apply)

<input type="checkbox"/> Cardiac Disease (Current/Past)	<input type="checkbox"/> Neurologic Disorders (Current/Past)	<input type="checkbox"/> HIV Testing (Current/Past)
<input type="checkbox"/> Sickle Cell Anemia (Current/Past)	<input type="checkbox"/> Incompetent cervix (Current/Past)	<input type="checkbox"/> STD (Current/Past)
<input type="checkbox"/> Clotting Disorders (Current/Past)	<input type="checkbox"/> Respiratory Conditions (Current/Past)	<input type="checkbox"/> Mental Illness (Current/Past)
<input type="checkbox"/> Diabetes/Gestational Diabetes (Current/Past)		

PSYCHO/SOCIAL ISSUES (check all that apply)

<input type="checkbox"/> Drug Abuse (Current/Past)	<input type="checkbox"/> Alcohol Abuse (Current/Past)	<input type="checkbox"/> Smoker (Current/Past)
<input type="checkbox"/> Domestic Abuse (Current/Past)	<input type="checkbox"/> Housing Issues	<input type="checkbox"/> Lack of support system

PRENATAL CARE AND NUTRITION (check all that apply)

<input type="checkbox"/> Currently enrolled in WIC	<input type="checkbox"/> Alcohol Abuse (Current/Past)	<input type="checkbox"/> Smoker (Current/Past)
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List of Medications:

Description of above or other unlisted conditions:

PROVIDER INFORMATION

Provider Signature	Provider Printed Name
Provider Address	Provider Phone #
Delivery Hospital	Provider Fax#